## Standard Response to Verification of Employment

Employers will provide requested information normally maintained on employees. If additional information not listed on this form is needed, please contact the employer.

	PAYROLL SECTION - Empl	loyee Personal Information	
Full Name:			
	Last	First	M.I.
Residential			
Address, if known:	Street Address		Apartment/Unit #
	City	State	ZIP Code
Mailing Address,			
if known:			
	Street Address		Apartment/Unit #
	Cit.	Ct -t-	710 C - J -
	City	State	ZIP Code
Home Phone:		Alternate Phone:	
E-mail Address, if I	known:		
Social Security Nu	mber:	Date of Birth:	
	Fmployer and	Job Information	
E a a la caración de			
Employment Statu	is: Currently Employed Termi		
Title:		Dates of Employment:	
		Employer	
Employer Name:		Address:	
Employer		Employer	
Phone Number:		Fax Number:	
Federal EIN:			
		- Begin Date:	End Date:
Full/Part Time or Seasonal:	☐ Full Time ☐ Part Time	<del></del>	-
	Seasonal	hetuiii to work Date.	
Employee Work Si			
Termination Reaso	on:	У	
	Wage In	formation	
Pay Cycle/Frequer	ncy:	Rate of Pay: \$	
Gross Pay Per Perio			
Current Year-to-Da	ate Farnings: \$		

Previous Calendar Year Earnings: \$	
Union Name:	Local Number:
Mandatory Union Dues: \$	Mandatory Retirement: \$
Tax Filing Status: Single Married	☐ Head of Household
Number of Dependents:	
Workers' Compensation: Yes No	
Name of Workers' Compensation Company and Contact Information:	
Cert	tification Information
Completed by:	
Employer Name (Employee's Employer):	
Data	
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## **HEALTH INSURANCE SECTION - Employee Personal Information**

-ull Name:						
Last			First		M.I.	
Last 4 digits of Social Security Nu	mber:					
	Не	alth Insurai	nce Availability			
Door the employer offer health		artii iii Sara	☐ Yes ☐	□ No		
Does the employer offer health		ا نديرد مط +نا النير		NO		
If not available currently to the			_			
Is health insurance available for			Yes	No		
	yroll Deduction	_				
Has the employee enrolled self	and/or depender	nts? 🗌 Se	elf Depe	ndents		
		Medical	Insurance			
Insurance Provider's Name:						
Insurance Provider's Address:						
Insurance Provider's Phone:			Fax:			
Policy/Contract Number:				oloyee Coverage:		
Policy Group Name/Number:			Cost for Liste	ed Children: \$		
			Cost for Emp	oloyee/Family: \$		
			Cost Freque			
Complete the following inform	ation for each dep	endent:				
Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date
(Last, 1 list, Wildele)	Ivamber	Direit	Number	Number		
		l				
		Dental I	nsurance			
Insurance Provider's Name:						
Insurance Provider's Address:						
insulance Frovider 37 (duress.						
Insurance Provider's Phone:			Fax:			
5 lt (6 · · · · · · · · · · ·				oloyee Coverage:		
Policy Group Name/Number:						
-				oloyee/Family: \$		
			Cost Freque			

## Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

		Vision I	nsurance			
Insurance Provider's Name:						
Insurance Provider's Address:						
Insurance Provider's Phone:						
Policy/Contract Number:			Cost for Em	nployee Coverage:	\$	
Policy Group Name/Number:			Cost for Lis	ted Children: \$		
			Cost for Em	nployee/Family: \$_		
			Cost Frequ	ency:		
Complete the following informa				1		T
Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date
	Pr	escription	Drug Insurance	e		
Insurance Provider's Name:		_				
Insurance Provider's Address:						
_						
Insurance Provider's Phone:			Fa	X:		
5 1: (6				nployee Coverage:		
Policy Group Name/Number:				ted Children: \$		
_			— Cost for Em	nployee/Family: \$		
			Cost Frequ	ency:		
Complete the following informa	ation for each dep	endent:				
Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Insurance Provider's Address:									
Insurance Provider's Phone:			Fax	:					
Policy/Contract Number:			Cost for Employee Coverage: \$						
Policy Group Name/Number:									
					Cost for Employee/Family: \$				
		Cost Frequency:							
Complete the following inforn		endent:							
Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date			
_									
Insurance Provider's Address:									
nsurance Provider's Phone:			Fax	:					
Insurance Provider's Phone: Policy/Contract Number:			FaxCost for Emp	: oloyee Coverage:	\$				
Insurance Provider's Phone: Policy/Contract Number:			Fax Cost for Emp Cost for List	:oloyee Coverage: ed Children: \$	\$				
Insurance Provider's Address:  Insurance Provider's Phone:  Policy/Contract Number:  Policy Group Name/Number:			Fax Cost for Emp Cost for Liste Cost for Emp	:	\$				
Insurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number:			Fax Cost for Emp Cost for List	:	\$				
nsurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number:			Fax Cost for Emp Cost for Liste Cost for Emp	:	\$				
nsurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number: Complete the following inforn	nation for each dep	pendent: Date of	Fax Cost for Emp Cost for Liste Cost for Emp Cost Freque Group	:	\$				
nsurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number: Complete the following inforn	nation for each dep	pendent: Date of	Fax Cost for Emp Cost for Liste Cost for Emp Cost Freque Group	:	\$				
Insurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number: Complete the following inforn Name	nation for each dep	pendent: Date of	Fax Cost for Emp Cost for Liste Cost for Emp Cost Freque Group	:	\$				
nsurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number: Complete the following inforn	nation for each dep	pendent: Date of	Fax Cost for Emp Cost for Liste Cost for Emp Cost Freque Group	:	\$				
Insurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number: Complete the following inforn	nation for each dep Social Security Number	pendent: Date of Birth	Fax Cost for Emp Cost for Liste Cost for Emp Cost Freque Group	:	\$				
nsurance Provider's Phone: Policy/Contract Number: Policy Group Name/Number: Complete the following inform Name (Last, First, Middle)	nation for each dep Social Security Number	pendent: Date of Birth	Cost for Emp Cost for Liste Cost for Emp Cost Freque Group Number	:	\$				
Policy/Contract Number: Policy Group Name/Number: Complete the following inform Name (Last, First, Middle)	nation for each dep Social Security Number	pendent: Date of Birth	Cost for Emp Cost for List Cost for Emp Cost Freque Group Number	:	\$				
nsurance Provider's Phone:Policy/Contract Number:Policy Group Name/Number:Policy Group Name/Number:Policy Group Name (Last, First, Middle)  Completed by:  Name and Title:	nation for each dep Social Security Number	pendent: Date of Birth	Cost for Emp Cost for List Cost for Emp Cost Freque Group Number	:	\$				
nsurance Provider's Phone:Policy/Contract Number:Policy Group Name/Number:Policy Group Name/Number:Policy Group Name/Number:Policy Group Name (Last, First, Middle)  Completed by: Name and Title:Policy Group Name:	nation for each dep Social Security Number	pendent:  Date of Birth	Cost for Emp Cost for List Cost for Emp Cost Freque Group Number	:	\$				